DO NOT CUT FORM IN HALF **ORIGINAL SIGNATURES REQUIRED**

FRANKLIN COUNTY TRANSPORTATION SYSTEM MEDICAL ASSISTANCE MEDICAL MILEAGE REIMBURSEMENT

THIS FORM MUST BE FILLED OUT COMPLETELY AND SIGNED IN ORDER TO BE PROCESSED FOR PAYMENT.

All signatures must be original; NO stamps or copies accepted.

I certify that _____ received service/product on the stated date and time and that the service/product received is billable to the Pennsylvania Medical Assistance Program through Pennsylvania Department of Welfare.

Date of Service _____ Time of Service _____ AM / PM

** Physician/Therapist/Counselor/Pharmacist **Signature** (Please also print last name if illegible) Date

** Signature indicates that medical professional is attesting that the information contained in thes document is true and correct

Provider / Facility Name | Street Address, City, State, and Zip Code | Phone Number

The 1 -way trip mileage to the service/treatment which is being billed to the PA Medical Assistance Card is _____. (Whole number, no tenths)

The 1 -way return trip mileage from service/treatment which is being billed to the PA Medical Assistance Card is _____. (Whole number, no tenths)

_____ * Medical Assistance Recipient (Over age 18) or Parent/Guardian. No photocopies.

Original Signature of MA Recipient

Street Address (Including City, State, and Zip Code of MA Recipient) Phone Number

Transportation to and from appointment provided by _____. _____

First and Last Name Vehicle Plate Number

My signature validates that all information provided is true and accurate and that I was not transported with or by another participant of the MATP Mileage Reimbursement Program. Return completed form to 201 Franklin Farm Lane, Chambersburg, PA 17202, Attn: Odessa

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